SECTION I:

OVERVIEW OF DEPARTMENTAL OPERATIONS

Overview of Departmental Operations

Our mission is to enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services.

INTRODUCTION

This is the second Accountability Report for the U.S. Department of Health and Human Services (HHS), but the first as an official member of the U.S. CFO Council pilot program being conducted under the auspices of the Government Management Reform Act (GMRA) of 1994. This report contains a high level overview of the Department's operations, budget, programs, and performance. It also contains the Department's FY 1997 audited financial statements and auditor's opinion. Additionally, it contains many other streamlined financial reports required under various statutes.

HHS, one of the largest Federal departments, administers over 300 programs including Medicare, Medicaid, Temporary Assistance to Needy Families (TANF), Head Start, and many other lesser-known programs and initiatives. Many of our component agencies (called "Operating Divisions," or OPDIVs) are well known to the public, such as the Food and Drug Administration, the Centers for Disease Control and Prevention, the Administration for Children and Families, and the National Institutes of Health. We have an enormous impact on the lives of every American by: ensuring food safety, conducting research to fight disease, providing health services, fighting outbreaks of highly infectious diseases (such as the ebola virus), and ensuring that parents take financial responsibility for their children.

We operate in a current environment that is very different from the recent past. In this environment:

- Diseases are no longer easily contained by geographic borders. Ease of world-wide travel helps spread contagious foreign diseases on our shores. Imported foods have, on occasion, turned out to be contaminated with bacteria, making some of our citizens very sick.

- Health care costs are higher than necessary, in part because not enough Americans are taking enough responsibility for their own health and strengthening their resistence to disease by having healthier diets, exercising regularly, and stopping harmful behaviors such as smoking and drug and alcohol abuse.

- National demographic trends are placing stress on the Medicare Hospital Insurance Trust Fund, and long term solutions are needed to ensure that the program is sustainable into the forseeable future.

- The structure of the Medicare and Medicaid programs, which had been intended to provide some flexibility to health care providers, is being abused by those who would cheat the system.

- Measurements of performance are being mandated by the Government Performance and Results Act (GPRA) of 1993 and by good management, though our necessary reliance on our partners for program results creates a challenge for us to collect verifiable data on performance.

- Successful government reinvention and downsizing efforts have resulted in the loss of many valuable employees. Additionally, many administrative functions have seen reductions in staffing levels as program areas benefited from the shift in resources to better directly serve our customers. In order for HHS to operate at optimal levels with existing resources, there needs to be increased emphasis on prioritization, training, workforce planning, and in improving the quality of worklife.

- Legislation affecting both our programs (such as welfare reform) and our administrative operations (including debt collection, financial reporting, information systems, etc.) has occurred at a rapid pace. Meanwhile, all of the legislative and operation requirements of the past still pose a continuing demand on resources.

- Information technology hardware is becoming less expensive and data is now more accessible to the general public than ever before. The Internet has provided an inexpensive forum to distribute all kinds of information to our customers. Yet, our operational reliance on information systems are being impacted by the looming Year 2000 problem, which promises to be very expensive to resolve.

- The number of Americans without health insurance is estimated to be between 41 to 44 million (10 million of which are children), and even those who are insured can still be financially devastated by serious illnesses.

- Acquisitions processes are being streamlined so that technology is more up-to-date by the time it is installed and operational.

In order to better operate in our current, complex, and demanding environment, in FY 1997 HHS established the following strategic goals:

- Reduce the major threats to the health and productivity of all Americans.
- Improve the economic and social well-being of individuals, families, and communities in the United States.
- Improve access to health services and assure the integrity of the nation's health entitlement safety net programs.
- Improve the quality of health care and human services.
- Improve public health systems.
- Strengthen the Nation's health sciences research enterprise and enhance its productivity.

Our future activities will be guided with reference to these goals and their accompanying performance targets, which are being developed for FY 1999.

INDICATORS OF OUR SUCCESS

Until our GPRA efforts are fully implemented for tracking performance results, our success in achieving these goals has been measured, in part, by the long-standing Healthy People 2000 (HP2000) program, which was conceived long before the enactment of GPRA. HP2000 was initiated in 1979 by HHS, leading a consortium of over 300 organizations to identify the nation's health priorities and goals, and track our progress toward meeting those goals. HP2000 focuses on three broad goals of increasing the span of health life, reducing health disparities, and achieving access to preventive services for everyone. There are 22 priority areas identified such as physical fitness, nutrition, tobacco, and mental health. In support of these priority areas are a total of 319 quantitative objectives being tracked by HP2000. The most recent data available (through 1995) on the progress achieved in those areas being monitored by the program are found in *Healthy People 2000 Review: 1997*.

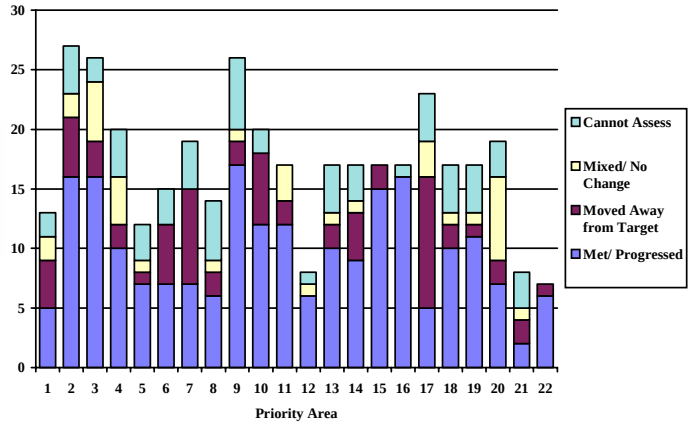
The following summary of progress is based on 319 unduplicated objectives. At the midpoint of the decade, 13 percent of the objectives have reached or surpassed the year 2000 targets. Progress toward the targets has been made for another 43 percent of the objectives, and 18 percent show movement away from the targets. Data for 7 percent of the objectives show mixed results and 2 percent show no change from the baseline. Data beyond the baseline have been obtained for 30 objectives that had only baseline data last year. Now only 44 objectives (14 percent) have baseline data but have no additional data with which to evaluate progress (several objectives in this category have supplemental data that cannot be used for determination of progress). Four new baselines were obtained this year and baselines have yet to be obtained for 11 objectives (3 percent). The accompanying charts show the progress of the objectives by priority area.

Healthy People 2000 Objectives:
Summary of Progress by Priority Area

Priority Area	Met/ Progressed	Move Away from Target	Mixed/ No Change	Cannot Assess	Total Objectives
1. Physical Activity and Fitness	5	4	2	2	13
2. Nutrition	16	5	2	4	27
3. Tobacco	16	3	5	2	26
4. Substance Abuse: Alcohol and Other Drug	10	2	4	4	20
5. Family Planning	7	1	1	3	12
6. Mental Health and Mental Disorders	7	5	0	3	15
7. Violent and Abusive Behavior	7	8	0	4	19
8. Educational and Community-Based Progra	6	2	1	5	14
9. Unintentional Injuries	17	2	1	6	26
10. Occupational Safety and Health	12	6	0	2	20
11. Environmental Health	12	2	3	0	17
12. Food and Drug Safety	6	0	1	1	8
13. Oral Health	10	2	1	4	17
14. Maternal and Infant Health	9	4	1	3	17
15. Heart Disease and Stroke	15	2	0	0	17
16. Cancer	16	0	0	1	17
17. Diabetes and Chronic Disabling Condition	5	11	3	4	23
18. HIV Infection	10	2	1	4	17
19. Sexually Transmitted Diseases	11	1	1	4	17
20. Immunization and Infectious Diseases	7	2	7	3	19
21. Clinical Prevention Services	2	2	1	3	8
22. Surveillance and Data Systems	6	1	0	0	7

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics.

Healthy People 2000 Objectives:
Summary of Progress by Priority Area



[Source: *HP2000 Review: 1997]*

In September 1997, HHS released ***Developing Objectives for Healthy People 2010*** for public comment. The following criteria have been established for attributes of HP 2010 Objectives:

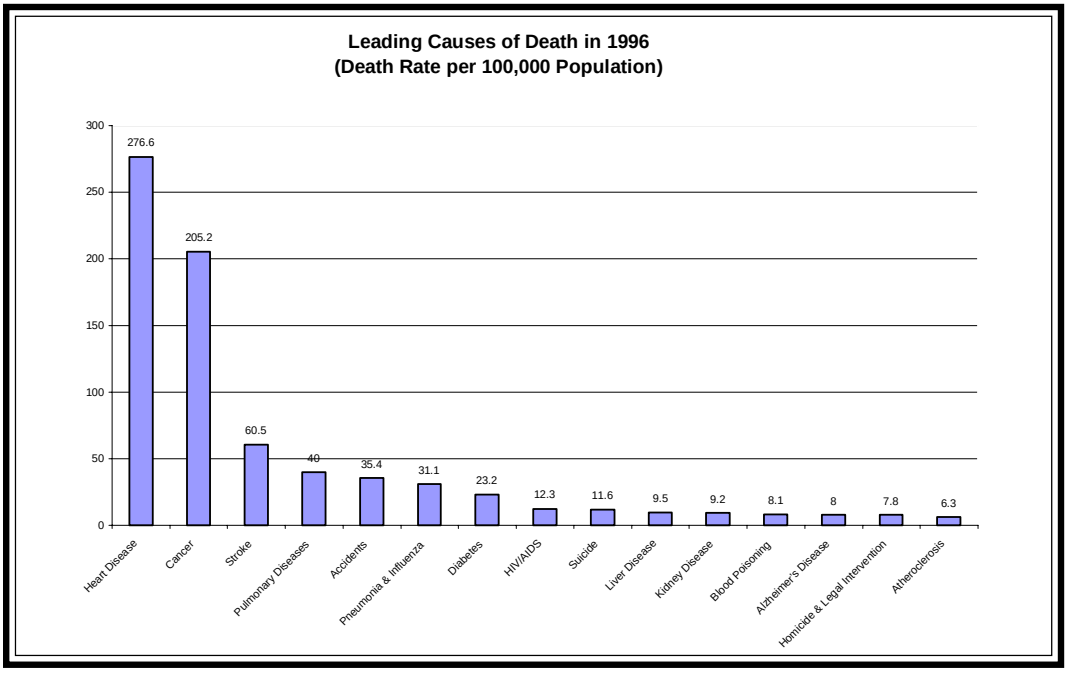
- Important and understandable,
- Prevention-oriented,
- Action-driven,
- Useful and relevant,
- Measurable,
- Comparable, and
- Supported by scientific evidence.

STATUS OF HEALTH IN AMERICA

There is no easy way to capture the status of health in America today. Illness incidence rates within total populations can vary by age, race, and sex. There are year-to-year fluctuations in the rates of death for every type of illness and accident. Additionally, access to care and affordability are also important health issues because untreated minor illnesses can mushroom into emergency room crises with much higher costs in the long run. Though insufficient preventive health care (at the personal or national level) often proves to be "Penny-wise and pound foolish," national prevention programs are covered by the limited discretionary dollars available. Our preparedness for potential virus outbreaks, the safety of our food supply, and the effectiveness and safety of our medical treatments also impact the status of health in America. Here then, are just a few of the myriad measures of the status of health in America (Source: ***HP 2000: 1997***, unless otherwise noted).

- First, second, and third leading causes of death: Heart disease, cancer, and stroke
- Percentage of adults leading sedentary lifestyles: 24%
- Percentage of adults who had some type of mental or substance abuse disorder in a recent year: almost 30%.
- Estimated percentage of low birthweight babies attributed to cigarette smoking: 17-26%
- Deaths per year attributed to cigarette smoking: 430,000
- Number of annual deaths related to homicide and suicide: over 50,000
- Rate of increase in child abuse and neglect over 1986 baseline: 85%
- Percentage of uninsured Americans: 17% (Source: Medical Expenditures Panel Survey (MEPS))
- Cost of work-related injuries in 1993 (including medical care, lost productivity, and wages): $121 billion
- Proportion of homes with radon testing: 11%
- Percentage of adults over 35 making regular dental visits: 61%

The status of our health tomorrow is greatly impacted by what we do today: the level and effectiveness of prevention efforts, the level of toxins we allow in our environment, the focus and direction of our health research efforts, and the level of responsibility and action taken by Americans to insure their own health, to name just a few factors. HHS' health programs address these and many other factors, keeping an eye on the future.



TRENDS IN THE WELL-BEING OF AMERICA'S FAMILIES

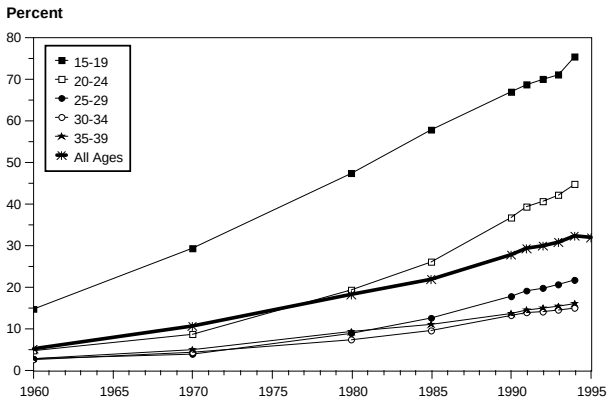
In addition to the Department's involvement with health issues, family issues are also the subject of many of our programs. While a "picture" of the status of the American family is as difficult to portray as it is for the Nation's health, we provide here some insight into just a few of the concerns facing our children today.

Births to Unmarried Mothers

Children who are born to single mothers – regardless of the age of the mother – are considerably more likely than children born to two parents to grow up poor, to spend large portions of their childhood without two parents, and to become single parents themselves.

Between 1960 and 1994, there was a considerable increase in the percentage of all births to unmarried mothers – from 5.3 percent in 1960 to 32.6 percent in 1994. However, preliminary data for 1995 indicate a small decline in the percentage of all births to unmarried mothers, to 32.0 percent.

Percentage of All Births to Unmarried Mothers by Age of Mother.



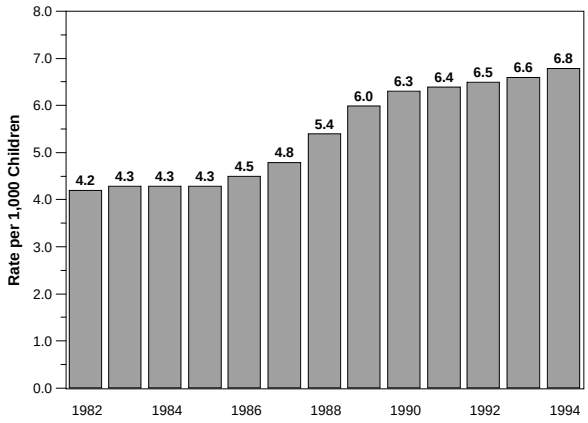
Source: 1997 Trends in the Well-Being of America's Children and Youth

Children Living in Foster Care

A child is placed in foster care when a court determines that his or her family cannot provide a minimally safe environment. This determination often follows an investigation by a state or county child protective services worker. Placement most commonly occurs either because a member of a household has physically or sexually abused a child or because a child's caretaker(s) has severely neglected the child. In some cases, children with severe emotional disturbances may also be put into foster care.

The number of children in foster care rose sharply from 262 thousand in 1962 to 462 thousand in 1994. The rate of children living in foster care (*i.e.,* the number of children in foster care per one thousand children under age 18) also rose dramatically during the same time period, from 4.2 foster children per one thousand children under age 18 in 1982 to 6.8 in 1994 – an increase of over 60 percent. Between 1990 and 1994, the rate of children in foster care continued to increase, but at a slower pace.

Children Living in Foster Care: 1982-1994 (Rate per thousand).



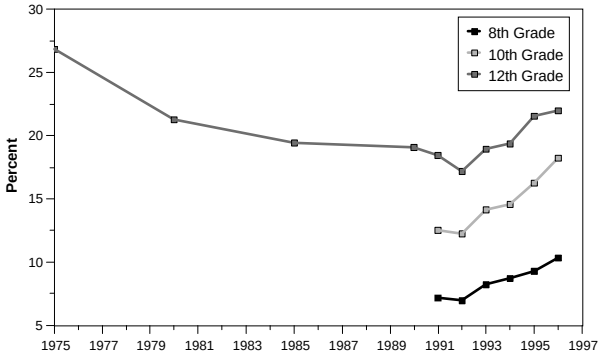
Source: 1997 Trends in the Well-Being of America's Children and Youth

Cigarette Smoking Among Youth

Cigarette smoking is the single most preventable cause of death in the United States. The CDC estimates that one in five deaths are caused by tobacco use. Youthful smoking can have severe, lifelong consequences because a large proportion of those who initiate smoking in adolescence will continue to smoke as adults. In addition, youths who smoke are also more likely to use illicit drugs and to drink more heavily than their peers who do not smoke.

- Daily smoking among 12th grade students had decreased sharply in the late 1970s, but has begun to increase again in recent years. Between 1992 and 1996, the percentage of 12th graders who reported smoking daily increased from 17.2 percent to 22.2 percent.
- Data for 8th and 10th grade students, available from 1991 through 1996, also show recent increases in the percentage of students who reported smoking daily, from 7.2 percent to 10.4 percent among 8th grade students and from 12.6 percent to 18.3 percent among 10th grade students.
- Increases in the prevalence of current smoking among youths are also reflected in the results from the Youth Risk Behavior Survey. Current smoking means smoking on one or more of the previous 30 days.

Percentage of 8th, 10th, and 12th Grade Students Who Report Smoking Cigarettes Daily Over the Previous 30 Days: 1975-1996.



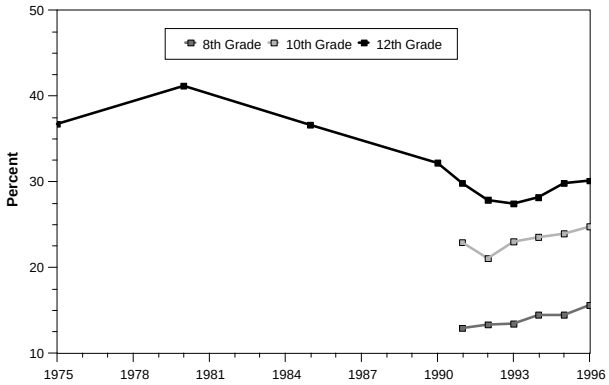
Source: 1997 Trends in the Well-Being of America's Children and Youth

Binge Drinking Among Youth

Alcohol use among adolescents is linked to a host of problems including motor vehicle crashes and deaths, difficulties in school and the workplace, fighting and breaking the law. In addition, binge drinking by youths – having five or more drinks in a row at some point in the previous two weeks – is associated with higher levels of illicit drug use.

Among 12th grade students, rates of binge drinking fell from a high of 41.2 percent in 1980 to 27.5 percent in 1993. Between 1993 and 1996, rates have edged up modestly to 30.2 percent.

Binge Drinking: Percentage of 8th, 10th, and 12th Grade Students Who Reported Having Five or More Drinks in a Row in the Previous Two Weeks: 1975-1996.



Source: 1997 Trends in the Well-Being of America's Children and Youth

PERFORMANCE MANAGEMENT

With the passage of GPRA, Federal agencies were given a valuable tool in ensuring that agencies identify long term strategies for achieving quantifiable goals which represent programmatic success. Our efforts to implement the GPRA will focus on measuring performance of specific HHS programs, a different, but complimentary, approach than is taken by HP 2000 which establishes goals for various health issues. The accompanying timeline shows the milestones and accomplishments achieved to date in HHS performance management.

HHS Performance Management Implementation Timeline of Accomplishments

YEAR	EVENT
1979	• Healthy People 2000 initiative identified comprehensive, long-term targets for improving the health of the American population. This initiative is still operational.
1991	• Beginning this year, HHS prepares an annual Financial Management Status Report and Five Year Plan, documenting performance planning, measures, and accomplishments of the OPDIVs in the financial management, grants management, and information systems areas, in particular.
1993	• OPDIVs identify 180 performance measures in the Five Year Plan, 75% of which already had trend data. • The Social Security Administration (SSA) - then a part of HHS, had already developed a strategic plan. • August 2, 1993, the Government Performance and Results Act (GPRA) is enacted.
1994	• Department initiates development of a Departmental strategic plan. • FDA (Prescription Drug Program) and ACF (Child Support Enforcement program) were accepted into the OMB GPRA Pilot Program for performance planning. • ASMB provided GPRA training to OPDIVs. • ACF, AoA, HCFA, HRSA, and SSA were active in HHS' internal pilot program effort.
1995	• Three additional OPDIVs participated in internal HHS pilot programs. • HHS and USDA initiated the interagency Research Roundtable to identify performance measurement methodologies for research organizations. • FDA ultimate approval times for applications under the Prescription Drug User Fee Act (PDUFA) pilot program declined from 21 months (early 1990's) to 15 months.
1996	• Completed initial draft of the HHS strategic plan. • Piloted performance/budget linkage with a performance plan for at least one program per OPDIV for the FY 1998 budget submission. • Initiated the HHS GPRA Roundtable for information exchange within HHS. • Continued technical assistance and training for and with OPDIVs. • Over 46 performance goals/activities were identified across the Department.
1997	• Completed HHS strategic plan. • Conducted Congressional consultations on the HHS strategic plan. • Coordinated the HHS strategic plan with States, local governments, and other stakeholders. • Conducted individual OPDIV status presentations on GPRA implementation for Office of Management & Budget (OMB) and the Department. • Completed the HHS annual performance plan, including individual OPDIV performance plans. • Considered the annual performance plans as part of the FY 1999 budget decisionmaking process. • Provided performance information in the first HHS Accountability Report covering FY 1996.

ACCOMPLISHMENTS

HHS had a long list of programmatic and managerial accomplishments in FY 1997. While the benefits of programmatic accomplishments are more obvious to the public, managerial accomplishments help to ensure that we are better stewards of the resources entrusted to us to run our programs. Some major accomplishments are highlighted here.

ACHIEVING IMPROVEMENTS IN NATIONAL HEALTH STATISTICS

In FY 1997, statistics became available which represent improvements in national health in a variety of areas. The HIV/AIDS mortality rate declined 26 percent between 1995 and 1996, falling from the leading cause of death among 25-44 year-olds to the second leading cause of death in that age group. Also, life expectancy reached an all-time high of 76.1 years and infant mortality reached another new low of 7.2 deaths per 1,000 live births. Age-adjusted firearm mortality, which had increased 22 percent between 1985 and 1993, dropped 11 percent between 1993 and 1995. From 1976-80 and 1988-94, the prevalence of hypertension in adults declined from 39 to 23 percent. Also, recent studies showed that the disability rate among older Americans declined dramatically (14.5%) from 1982 levels.

DECREASING WELFARE ROLLS/ IMPLEMENTING WELFARE REFORM

In 1997, HHS announced that the welfare caseload fell by 3.4 million recipients, from 14.1 million in January 1993 to 9.8 million in September 1997, a drop of 31 percent since the Clinton Administration took office. Forty-nine out of fifty states have seen their caseloads decline, with twenty-five states reducing their rolls by 40 percent or more in the last four years. This is the largest welfare caseload decline in history and represents the lowest percentage of the population on welfare since 1970. According to an analysis released in 1997 by the Council of Economic Advisors (CEA), the reduction in the welfare rolls can be attributed to the strong economic growth during those years, the waivers granted to states to test innovative strategies to move people from welfare to work, and other factors, such as the Administration's expansion of the Earned Income Tax Credit.

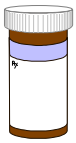
MAKING HEALTH RESEARCH AND INFORMATION MORE ACCESSIBLE TO THE PUBLIC

In April 1997, Vice President Gore and Secretary Shalala launched ***Healthfinder,*** a new government gateway site on the Internet that will make it much easier for most Americans to find health information on the World Wide Web. ***Healthfinder*** can lead people to information that addresses not only the leading causes of death, like heart disease and cancer, but also the root causes of the problems behind them – like smoking, unhealthy diets, physical inactivity, and substance abuse. The site is located at *[http://www.healthfinder.gov].*

> ***"We hear a lot about how managed care is changing our health care system. What we don't hear is how the consumers themselves are changing it. More and more, they are turning to the Internet to get the health-related information they need. Healthfinder will provide the public with easier access to more quality federal consumer health information than is available now from any single source on the World Wide Web."***
>
> **Vice President Al Gore**
> **April 15, 1997 addressing the Partnerships for Networked Consumer Health Information '97 Conference**

In September 1997, the National Institutes of Health (NIH) expanded its consolidated consumer health information area. This resource now hosts over 150 of NIH's most popular on-line consumer health publications. The goal of this project is to make all of NIH's consumer health information available in one convenient area. From this area, users can also access NIH's Health Information Index. This extensive collection of medical subject terms allows users to quickly identify and access the on-line resources of the specific Institute(s) at NIH that conducts research on the disease of interest to them. The Consumer Health Information area is located at: *[http://www.nih.gov/health/consumer/conicd.htm].*

PROTECTING THE PUBLIC FROM DANGEROUS DIET DRUG INTERACTIONS



In September 1997, the Food and Drug Administration (FDA) asked the manufacturers of fenfluramine and dexfenfluramine to voluntarily withdraw both treatments for obesity from the market based on new evidence about significant side effects associated with the drugs. Studies showed that when the drugs were used in combination (referred to then as "fen-phen"), they presented an unacceptable risk of heart valve disease. Both companies agreed to voluntarily withdraw their drugs from the marketplace.

IMPROVING CONSUMER INFORMATION ON DIETARY SUPPLEMENTS LABELS

In September 1997, FDA issued final rules for the labeling of dietary supplements in order to help consumers make more informed decisions at the point of purchase. Millions of Americans are becoming more aggressive about maintaining good health, and are spending billions of dollars on nutritional supplements including vitamins, minerals, and herbal products. Given the vast array of supplements on the market, labeling can help ensure product quality and provide consumers with accurate information about certain potential health effects the product may have. (Certain claims, such as the "curing" of a disease, would, under the law, make a supplement a "drug" that would have to be approved before marketing.) FDA is working to help ensure that information in dietary supplement labeling is appropriate and informative for consumers.

ACHIEVING ADVANCES IN RESEARCH

HHS received approximately $7.2 billion (approximately 16.3%) of all Federal budget research funds in FY 1997. Most was appropriated to the NIH, though the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA) and Agency for Health Care Policy and Research (AHCPR) also received research funding. Among the many 1997 research advances were findings that:

- A "programmed cell death" mechanism underlies inherited Alzheimers's Disease, and may also underlie Huntington's Disease.
- Vitamin E and the drug selegiline delayed loss of function in daily activities in Alzheimer's patients by about 7 months.
- Anti-HIV drug cocktails restore partial immune function and can delay disease progression and death.
- Implantable cardiac defibrillators reduce deaths from arrhythmia.
- Retinoic Acid, a derivative of vitamin A, reverses emphesema in the lungs of laboratory rats.

CONTROLLING FOODBORNE ILLNESSES

In FY 1997, HHS had several accomplishments in addressing one of the nation's great health problems, foodborne illness.

In May 1997, the Secretaries of HHS and Agriculture, and the Administrator of the Environmental Protection Agency (EPA) delivered to the President a document entitled *Food Safety From Farm to Table: A National Food Safety Initiative*. This collaborative effort between the public and private sector began the Agency's increased focus on ensuring the safety of the nation's food supply. One of the key elements of this initiative is a National Early Warning System announced in January 1997 to track actively and combat outbreaks of foodborne illness. If a foodborne illness outbreak occurs at a fast food restaurant in one state, federal agencies can now work together to warn the public in multiple states and attempt to find the source of the contamination.

Another project in 1997 included FDA's telephone survey to identify trends in food handling practices, safe food selection, consumer knowledge and concerns related to foods. Lastly, the government launched many educational efforts such as the Food Safety Education Partnership and Fight BAC!, a national food education campaign aimed at promoting safe food handling practices by consumers. FDA, CDC and other federal agencies created a unified strategy in 1997 that seeks to protect the public from illness and death associated with contaminated foods. Next year's progression is expected to include the Fresh Produce Initiative, aimed at limiting hazardous microorganisms in domestic and imported fruits and vegetables.

Foodborne Illnesses

It is estimated that as many as 9,000 deaths and between 6.5 and 33 million illnesses in the U.S. each year are food-related. Hospital stays alone connected with these illnesses are estimated to cost more than $3 billion a year. Moreover, it is estimated that the cost for lost productivity is between $20 to $40 billion per year. In recent years, the Nation has witnessed several incidents of death and sickness caused by contaminated food. In November 1996 one child died and nearly 70 others were injured due to an *E.coli* infection found in unpasteurized apple juice. Foods contaminated with pathogens in 1997 included unpasteurized juices, egg and egg products, oysters, raspberries, and meats.

PREVENTING, DETECTING, AND PROSECUTING MEDICARE AND MEDICAID FRAUD

On September 29, 1997, HHS announced that the Department's expanded efforts to fight fraud and abuse in health care are paying off, with unprecedented levels of recoveries and prosecutions. In FY 1997, HHS identified $1.2 billion in fines, restitutions, settlements, and recoveries – the most ever identified in one year. The FY 1997 total was six times higher than recoveries for FY 1996, and over three times higher than the previous best year for recoveries. In addition, criminal and civil prosecutions totaled 1,340 cases in FY 1997 – double the number for FY 1996, and more than five times the total number in FY 1995. Over 2,700 health care providers and entities were excluded from doing business with Medicare, Medicaid, and other Federal and State health care programs for engaging in fraud or abuse of the programs – an 93% percent increase from the 1,400 exclusions in FY 1996. Since 1993,

actions affecting HHS programs alone have saved taxpayers more than $20 billion and increased health care fraud convictions by 240 percent.

On September 15, 1997, President Clinton announced three new weapons to fight fraud and abuse in the home health care industry, the fastest growing part of the Medicare program. The President announced: (1) an immediate moratorium (subsequently lifted on January 13, 1998) on all new home health providers coming into the Medicare program while HHS implements new regulations to prevent risky providers from entering the program; (2) a new and improved renewal process for home health agencies currently in the program to help weed out fraudulent providers; and (3) a doubling of audits to help increase detection of fraud and abuse. In addition, the Clinton Administration in March 1997 proposed a new regulation that would revise the Federal standards, called Conditions of Participation, that home health care providers must meet in order to participate in the Medicare program. The new rule, included at the President's urging in the Balanced Budget Act (BBA) of 1997, requires applicants to provide their social security numbers and employer identification numbers so HCFA can check for past fraudulent activity, and to conduct criminal background investigations on the staff they hire. The BBA will further reduce fraud and abuse in home health care by establishing a prospective payment system for home health services, tightening eligibility (by requiring a surety bond), and developing guidelines for use of home health services.

For 30 years, health care expenditures in the United States have risen faster than inflation and population. One contributing factor is the unnecessary cost of fraud, waste, and abuse. Operation Restore Trust (ORT) is a long-term Secretarial initiative, in partnership with the Department of Justice, to reduce the incidence of fraud, waste, and abuse in Medicare and Medicaid. It has two distinct phases: (1) a two-year demonstration confined to five States and specific program areas; and (2) a multi-year continuation which will institutionalize across the two programs and the country the best practices" refined in the demonstration. This project helps assure that payments for health care are reasonable and provided only when medically necessary. The large increases in health expenditures (both appropriate and inappropriate) have caused significant financial stress on the Federal budget, State budgets, and on the beneficiaries who pay "out-of-pocket" coinsurance. ORT is designed to help protect beneficiaries from health care providers that unfairly, and often illegally, seek to enrich themselves.

The lack of comprehensive baseline data on the incidence of payment errors has confounded program managers since the 1966 inception of the Medicare program. Audits of HCFA's FYs 1996 and 1997 financial statements yielded such baseline information for Medicare's fee-for-service program. ORT is designed to reduce payment errors that result from fraud and abuse. Accordingly, we believe that one way to measure the effect of ORT is to compute its "return on investment" by comparing ORT costs to generated savings. Our goal in the continuation of ORT is to have a return on investment in excess of $7 to $1. For example, the OIG devoted approximately $70 million in FY 1997 in support of its Medicare program safeguard activities. These expenditures yielded audit and investigative receivables and implemented funds to be put to better use in excess of $7 billion.

We will continue ORT activities to reduce the incidence of payment errors in government health programs. Our interim goal is to reduce the Medicare claims payment error rate. We are also exploring the feasibility of using additional benchmarks, such as utilization/provider trends and other departmental GPRA measures.

Fraud Hot Line:	(410) 965-5933
Toll Free:	(800) 447-8477

IMPROVING FINANCIAL MANAGEMENT

During FY 1997, we made notable progress in the area of financial management, though we still face significant challenges. We completed our first Departmentwide financial statement audit and prepared our first annual Accountability Report covering FY 1996, identified action steps necessary to resolve audit findings, implemented various aspects of the Debt Collection Improvement Act (DCIA) of 1996, led the Department's GPRA efforts, and expanded our audit coverage to include full scope audits for CDC and NIH. This 1997 Accountability Report includes the first Departmentwide financial statements to have made "eliminations" adjustments to cancel out the effects of intra-entity transactions. The FY 1997 Departmentwide audit was completed almost five months faster than the FY 1996 audit, and our auditors opinion improved from a disclaimer in 1996 to a qualified opinion in 1997. Details of our financial management accomplishments and activities are found in Section III of this Accountability Report.

LAUNCHING CAMPAIGN TO INCREASE PHYSICAL ACTIVITY AMONG ADULTS

In August 1997, CDC unveiled its campaign to promote moderate physical activity among adults. The theme "It's Everywhere You Go" reinforced the fact that 30 minutes of moderate physical activity in a day five of more days of the week provide health benefits and fit easily into normal daily routine. A part of the campaign is a marketing kit that was developed for use by health professionals and community leaders across the nation and was made available on the Internet.

CHALLENGES

Our Nation faces enormous challenges to the health and well-being of our citizens. The challenges we face are both programmatic and administrative. The programmatic issues may get more public attention, but the administrative infrastructure issues (such as maintenance of our computer systems) are vital to the efficient delivery of health and social services.

IMPLEMENTING THE BALANCED BUDGET ACT (BBA) OF 1997

Under BBA, the Department is tasked with implementing a new Children's Health Insurance Program (CHIP), a new Medicare + Choices program, provisions to control Medicare benefit spending, and new fraud and abuse authorities. These new and expanded program responsibilities have put a significant strain on our current level of resources. We plan to implement the most important provisions on schedule, and we have advised interested parties that other provisions may be delayed.

To meet the challenge presented by limited resources, the Health Care Financing Administration (HCFA) is in the process of reorganizing its priorities. HCFA will shift as much of its limited resources towards BBA implementation as possible, without impairing the agency's mission to provide high quality health care services to Medicare and Medicaid beneficiaries and while maintaining efforts to combat health care fraud, waste and abuse. HCFA's top priority is to complete Year 2000 conversions of its many information systems on time. Implementing the provisions of BBA are next in priority with those provisions that save Federal trust fund dollars getting the higher priority.

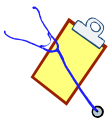
PROVIDING HEALTH CARE TO AMERICA'S UNINSURED CHILDREN

BBA provides the largest increase in funds available for health insurance for low-income children since the creation of Medicaid in 1965. HHS will be administering the $24 billion set-aside program for children, which allows States to extend health coverage to millions of uninsured children by expanding their current Medicaid programs or by creating new health insurance plans. There will be many challenges related to the administration of the program under the various structures designed by the States.

CONTROLLING SPIRALING HEALTH CARE COSTS

The cost of health care in America is at an all-time high, due to the increasing costs of high-tech medical treatment, the increasing incidence of health problems, and an aging population. The Federal portion of these rising costs has contributed to a substantial portion of the national budget. Medicare outlays now account for more than the entire Federal budget of 1966, the first year of the Medicare program. Fortunately, HHS has many programs that work synergistically to help identify ways to help keep health care costs down. These programs: determine the most effective medical treatments; spread the word about illness prevention through exercise and nutrition; prevent foodborne illnesses; reduce the spread of infectious diseases; evaluate the impact of environmental toxins on health; and detect and prosecute health care fraud.

ENSURING THE PRIVACY OF MEDICAL RECORDS



As the health care industry has become more automated with the electronic transmission of patient information for treatment and payment purposes, more and more people have access to information that used to be kept safe and private in our doctors' offices. HHS is working to ensure that patient privacy is ensured and that information is shared only with those having a 'need to know.'

> ***"Americans shouldn't have to trade in their privacy rights to get quality health care….We have federal laws that protect the privacy of video records, motor vehicle records, and credit cards. Yet the way we protect our most sacred family secrets, our medical records, is erratic at best – and dangerous at worst. … We must act now with national legislation to address this serious threat."***
>
> **Secretary Donna Shalala**
> **September 11, 1997 before the Senate**
> **Committee on Labor and Human Resources**

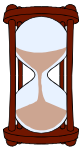
PERSUADING THE PUBLIC TO ADOPT HEALTHIER LIFESTYLES

Americans are leading busier and more stress-filled lives than ever before. It is difficult to persuade them to take the extra time to prepare healthier meals when a high-fat, fast-food meal is far more convenient. Many Americans also say they have difficulty finding the time for regular exercise. In fact, recent statistics in a Healthy People 2000 Report indicates that a quarter of Americans lead a sedentary lifestyle. Yet diet and exercise are the two key elements in preventing illnesses. If more Americans could be convinced to have healthier diets and to incorporate more physical activity in their daily routine, our Nation's physical and financial health would improve.

IDENTIFYING PROBLEMATIC DRUG INTERACTIONS

With the "fen-phen" scare of 1997, many Americans learned for the first time of the potentially dangerous side effects caused by drugs and drug interactions. Patients are often prescribed several drugs by their doctors for various ailments, but most often those drugs have not been tested in combination for safety. The public is understandably concerned about the safety of their prescriptions and drug interactions. FDA helps monitor potential dangers of drug and device-induced disease through MedWatch, the Medical Products Reporting Program. MedWatch is an initiative designed both to educate all health professionals about the critical importance of being aware of, monitoring for, and reporting adverse events and problems to FDA and/or the manufacturer; and to ensure that new safety information is rapidly communicated to the medical community. Consumers may also access MedWatch alert notices through the internet at [*http://www.fda.gov/medwatch*].

PREPARING FOR THE YEAR 2000



The approaching Year 2000 presents a huge challenge to computer systems around the world, including those at HHS. Existing computers were designed with only two digits to represent the year, so when the computers see "00" they will erroneously assume the year is 1900. This can cause unlimited problems in the transmission of data and money, and in the operations of computer-run mechanical devices. We are working to ensure that we have identified all of the work that needs to be accomplished, both with our own systems and with other systems that interface with our systems. And we have begun reprogramming millions of lines of computer codes.

MANAGING FOR PERFORMANCE

GPRA provided HHS with an important tool to enable us to manage our organization and allocate our resources in ways that will most effectively help us achieve our mission. Since 1993, we have been developing our strategic plans, goals, and performance measures so that we can better manage for performance. We have encountered challenges in such areas as: the complexities of managing HHS' 300-plus programs for performance; the common cultural mindset which resists the oversight nature of performance measurement; the absence of performance data collection mechanisms; the resistence to linking personal performance plans with organizational performance plans; and in the development of performance measures agreeable to all stakeholders.

PREVENTING VIOLENCE IN AMERICA'S HOMES

When most people think about violence, they think of violence in the streets perpetrated by a stranger. Sadly, the American home is the site of much of America's violence today, and the perpetrators are often family members and intimate partners. In FY 1997, HHS worked with the Department of Justice to implement new Federal anti-stalking and domestic violence laws which were signed by President Clinton in the last few days of FY 1996. In early FY 1997, Attorney General Reno and Secretary Shalala announced the publication of a technical assistance document, the "Community Checklist," to help ensure that every community in the country has resources in place for domestic violence prevention and intervention. Additionally, HHS and the Department of Justice are collaborating to implement several initiatives under the Violence Against Women Act including: grants to battered women's shelters, youth education on domestic violence, and coordinated community responses to prevent intimate partner violence.

Domestic Violence:
When Home is Not a Refuge

For too many American women, the family home is a place of fear. According to the National Woman Abuse Prevention Project, a woman is more likely to be assaulted, injured, raped, or killed by a male partner (or by a stalking former partner) than by any other type of assailant. Abuse is a major women's health problem and it often results in injuries that require medical treatment. According to the American Medical Association (1994), battered women account for 22-35% of all women seeking emergency medical services, 25% of women who attempt suicide, 23% of women who seek prenatal care, and 50% of women over 30 years old who have been raped. In response to the high cost of treatment for these injuries, some insurance companies have begun to deny coverage to victims of domestic violence (the abusers, however, are not denied coverage).

Unfortunately, a battered woman is most at risk when she attempts to flee, helping to explain why many abused women stay with their abuser. In 1995, 26% of all female murder victims were slain by their partners or ex-partners. (FBI, 1996) Abusers and stalkers who mean to do harm to their victims can be a threat to many others as well, including the victim's children, other family members, friends, and co-workers. Domestic violence has been ranked as a high security problem in a survey of corporate security directors, according to the Family Violence Prevention Fund.

Hot Line Number 1-800-799-SAFE

REDUCING MEDICARE PAYMENT ERROR RATES

While we have long known there are billing abuses in the Medicare program, the FY 1996 financial statement audit process gave us our first statistically valid error rate in our Medicare fee for service program. The FY 1997 financial statement audit found that, of the $177.4 billion in processed fee-for-service claims paid by HCFA in FY 1997, from $12.1 to $28.4 billion with an estimated midpoint of $20.3 billion (11 percent) were improper payments. Although 98 percent of the claims were paid correctly based on information submitted on the claim, when subsequent medical documentation was requested from providers, and the services were reviewed, the OIG found that the error rate was between 7 and 16 percent. Of the errors identified through this "look behind" review of claims, the OIG estimated that approximately 44% of the errors were due to insufficient or missing medical documentation. Another 37% of the errors were due to a lack of medical necessity. The audit has demonstrated the need for HCFA to increase oversight to ensure provider compliance with Medicare reimbursement rules and regulations.

RESOLVING MATERIAL FINANCIAL STATEMENT AUDIT FINDINGS AND IMPLEMENTING NEW ACCOUNTING STANDARDS AND REPORTING REQUIREMENTS

The financial statement audit process has proven very beneficial to HHS, as we explain in Section III. While we are not pleased to have as many material weaknesses and reportable conditions as currently exist, we have found that our efforts to resolve those issues are helping to improve our financial management systems and accounting services, and the way we manage our programs. Some of the audit findings in the FY 1997 audit will be resolved during FY 1998. Others, such as the Medicare error rate, will require both short and long-term solutions. Details on our efforts and progress in resolving our audit findings are addressed in Section III of this Accountability Report. In FY 1998, some of our most significant financial reporting challenges involves 1) improving the timeliness of the audit process, 2) increasing the frequency and number of general ledger accounts subjected to montly reconciliations, and 3) the implementation of the new reporting requirements for the Statement of Net Costs, Statement of Financing, Statement of Budgetary Resources, Statement of Custodial Activities, Supplemental Stewardship Statements as well as a re-formatted Statement of Changes in Net Position.

STREAMLINING AND REDESIGNING THE INDIAN HEALTH SERVICE (IHS)

IHS made significant progress in streamlining and reorganization in FY 1997. Since FY 1992 IHS Headquarters has downsized by over 50 percent and in FY 1997 implemented a reorganization plan which consolidated nine headquarters offices to three. Likewise, several IHS Area Offices have undertaken similar reorganization efforts to free up resources to support tribes managing their own health care programs. Given the funding levels IHS has experienced in recent years, balancing the mission of providing critical health care services while reducing administrative overhead and increasing tribal shares will be a continuing challenge well into the next century.

SUSTAINING THE MEDICARE TRUST FUNDS

The Balanced Budget Act (BBA) of 1997 helped extend the solvency of the Medicare Hospital Insurance (HI) Trust Funds for more than a decade by shifting home health care to the Supplementary Medical Insurance (SMI) Program. However, long term answers must still be found to maintain the viability of the trust funds as the Baby Boom ages.

FINDING THE ELUSIVE CURE FOR CANCER

Over the last several decades, cancer has climbed to be the second leading cause of death in America in spite of the many synergistic efforts at HHS working to respond to the cancer threat. Standard treatments (radiation and chemotherapy) are toxic to the patient as well as the cancer, and often result in weakened immune systems. Public dissatisfaction with the limited array and results of current treatment practices is indicated by the fact that many inquiries to NIH are requesting information on alternative cancer treatments. There is some good news. The cancer death rate fell slightly in 1996. In November 1997, the FDA approved the first biotechnolgy product to treat cancer; it has fewer toxic side effects than other mainstream cancer treatments. This issue has no easy solution but our scientists continue to conduct research in promising areas including gaining a better understanding of environmental impacts on our health. Until we find a cure, through our programs at CDC and other OPDIVs, we will continue to provide Americans with information on how to help prevent cancer with active lifestyles, healthy eating habits, and no smoking.

ORGANIZATIONAL STRUCTURE

HHS is headed by the Secretary of Health and Human Services, Donna Shalala, who is a member of the President's Cabinet. HHS is headquartered in Washington, DC and has 10 regional offices.

HHS includes over 300 programs administered by twelve components or Operating Divisions (OPDIVs), including the Office of the Secretary (OS) and the Program Support Center (PSC). The twelve OPDIVs (in descending order of program spending magnitude in FY 1997) are:

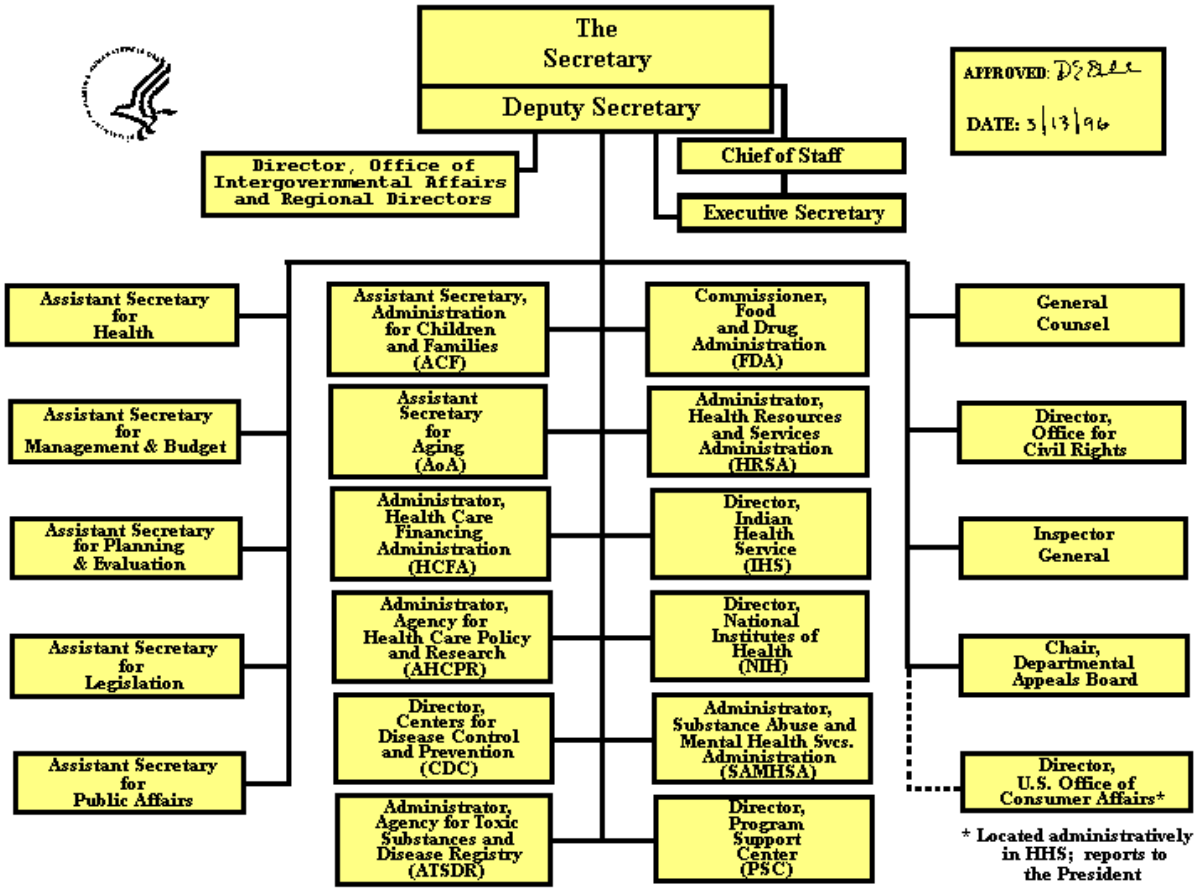
Health Care Financing Administration (HCFA)
Administration for Children and Families (ACF)
National Institutes of Health (NIH)
Health Resources and Services Administration (HRSA)
Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances and Disease Registry (ATSDR)
Indian Health Service (IHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Food and Drug Administration (FDA)
Administration on Aging (AoA)
Agency for Health Care Policy and Research (AHCPR)
Program Support Center (PSC)
Office of the Secretary (OS)

Our programs cover a wide spectrum of activities including:

- Medical insurance and service,
- Medical and social science research,
- Preventing the spread of infectious disease (including immunization services),
- Food and drug safety,
- Health advocacy and public awareness programs,
- Child care,
- Job training,
- Child support collection activities, and
- Cash assistance for needy families.

During FY 1995, HHS was reorganized when the Social Security Administration (SSA) left the Department. SSA had accounted for approximately half of the HHS budget. After the independence of SSA and additional organizational changes under Reinventing Government II (REGO II), the Vice President's governmentwide reinvention efforts, the structure of HHS was reestablished as illustrated in the accompanying organization chart. Another organization change will be the elimination of the U.S. Office of Consumer Affairs in FY 1998.

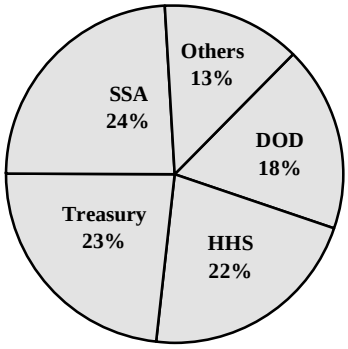
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES



BUDGETARY HIGHLIGHTS

In FY 1997, HHS had net outlays of $339.5 billion, representing 21.5% of all Federal net outlays. This represents an increase from $319.8 billion (20.5% of Federal net outlays) in FY 1996. Only SSA (which became independent from HHS in 1995) and the Department of the Treasury exceeded HHS spending in FY 1997.

Federal FY 1997 Outlays by Agency



Source: President's FY 1998 Budget. Figures are FY 1997 estimates. (Treasury includes interest on Federal debt.)

The portion of the Federal budget allocated to HHS has grown significantly over the last three decades. The nature of the HHS entitlement programs is the reason for the growth in spending. We cannot limit the number of enrollees in our programs; every individual who meets the programs' criteria must be enrolled. Nine out of every ten HHS dollars are now spent on entitlements.

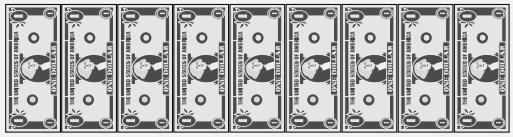
When the Medicare and Medicaid entitlement programs were enacted in 1966, HHS (excluding SSA) net outlays accounted for only 4% of Federal net outlays. As the ranks of the enrollees and beneficiaries of these entitlement programs has swelled along with the increasing costs of health care treatment, the impact on the Federal budget has been quite significant. *The net outlays for Medicare alone now account for more than the entire Federal budget of 1966.* (See accompanying chart).

HHS dollars are allocated to the OPDIVs across budget functions. The accompanying matrix chart of "HHS 1997 Net Outlays by Budget Function and OPDIV" details this distribution and facilitates the identification of concentrations of outlays. The largest single budget function is Medicare (which has a category all its own), with $189.9 billion in spending. The second largest functional category, at $117.5 billion, is Health where the bulk of the funds are spent by HCFA (for Medicaid) and NIH (for research). ACF has the bulk of responsibility for budget function dollars categorized as Education, Training and Social Services, and also for Income Security through the Temporary Assistance to Needy Families (TANF) and Child Support Enforcement programs.

FY 1997 HHS OUTLAYS

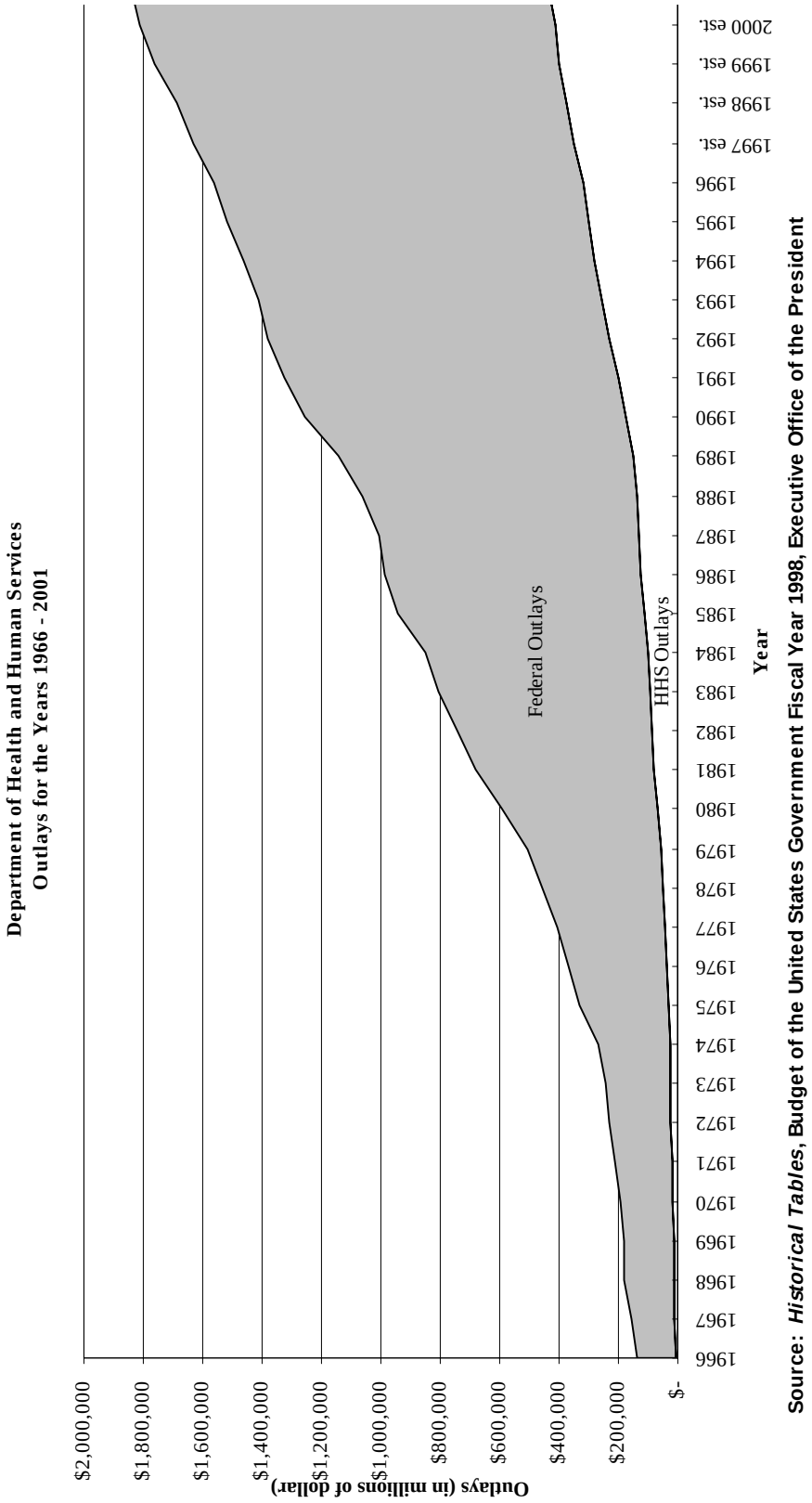
Entitlements vs. Discretionary Funds

Entitlements Outlays



Discretionary Outlays

Nine out of every ten 1997 HHS dollars were spent on entitlements.



Source: ***Historical Tables*****, Budget of the United States Government Fiscal Year 1998, Executive Office of the President**

HHS FY 1997 Net Outlays by Budget Function and OPDIV
(In Thousands)

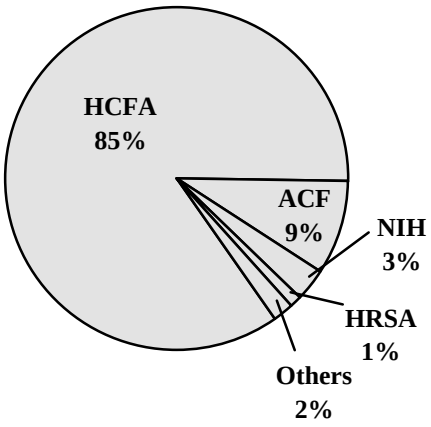
OPDIV	Training, Employment, and Social Services	Health Programs	Medicare Program	Income Security	Law Enforcement and Justice Assistance	Total
HCFA	$ -	$ 95,554,425	$ 189,968,721	$ -	$ -	$ 285,523,146
ACF	12,397,635	-	-	18,613,954	12,210	31,023,799
NIH	-	11,171,018	-	-	-	11,171,018
HRSA	-	3,525,740	-	-	-	3,525,740
CDC	-	2,248,056	-	-	-	2,248,056
IHS	-	2,138,906	-	-	-	2,138,906
SAMHSA	-	1,621,820	-	-	-	1,621,820
FDA	-	872,945	-	-	-	872,945
AOA	827,680	-	-	-	-	827,680
AHCPR	-	109,904	-	-	-	109,904
PSC*	-	224,430	-	-	-	224,430
OS	-	22,358	-	168,209	15,012	205,579
Total	$ 13,225,315	$ 117,489,602	$ 189,968,721	$ 18,782,163	$ 27,222	$ 339,493,023

* Though PSC's services are fee-based and self-sustaining, net outlays shown include $180.4 million for Commissioned Corp Retirement Pay with the remainder attributable to miscellaneous trust funds.

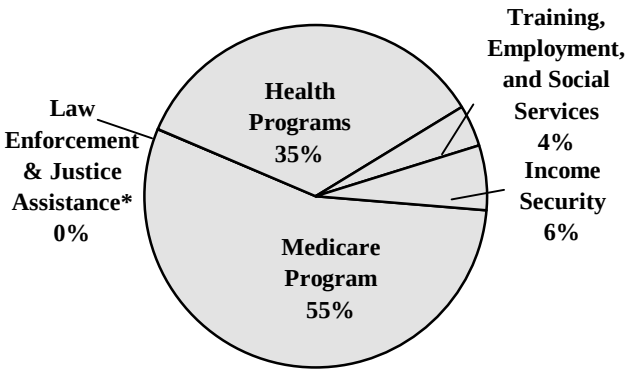
Measured by program spending, HCFA is by far the largest of the HHS OPDIVs, followed by ACF, then NIH, HRSA, etc. Their relative portion of total HHS net outlays is illustrated in the accompanying pie chart.

Outlays by budget function are largely concentrated in the Medicare and Health (including Medicaid) budget functions.

HHS FY 1997 Net Outlays by OPDIV



HHS FY 1997 Net Outlays by Budget Function



*** Less than .01%**